

Spenddown Process For Dental and Vision Expenses

Step 1

Verify the bill with the provider and ask for the following information if not listed on the bill or the information is unclear:

- Procedure codes (those billed to Medicaid) for all services
- Total Amounts billed
- Dates of Service
- Who the service was for
- Client's obligation after TPL (if the bill is an old bill, what is the client's obligation at the beginning of the benefit month?)
- Is the service considered an upgrade (service is medically necessary but not necessarily the Cadillac version)? (Composite fillings on back teeth, implants, tinted or scratch coating on lenses, frames above the Medicaid rate, etc.)
Cosmetic services are not allowed. See 415-8

See Step 4--

Step 2

Check the on-line Provider Manual for Dental or Vision to see if the Procedure code used is an allowable Medicaid expense. If the service was done before they had a Medicaid card, allow the expense. If the service was done while they had a Medicaid card and Medicaid is not paying for the service, do not allow the expense. *

Dental <http://health.utah.gov/medicaid/pdfs/dental/archive/dental10-05.pdf>

Vision <http://health.utah.gov/medicaid/pdfs/VISION/archive/vision7-05.pdf>

Note: These PDF files are updated periodically. Check to make sure you have the most current version.

Step 3

For adult diapers (anyone over the normal diaper age) and eyeglass frames and lenses, check MMIS for the allowable Medicaid rate. We only allow the Medicaid rate for these expenses. For the lenses, each lens is listed separately. Allow an expense for each lens.

[MMIS Instructions](#)

Step 4

If the expense is considered an upgrade to a medically needy service, we can allow what the provider would charge for the normal cost of the service before the upgrade. For example: The client chooses to have white (composite) fillings put on back teeth. This is an upgrade and Medicaid will only pay for amalgam (metal) fillings. You can allow the amount the provider would charge for the amalgam filling even though the upgrade was done.

* If the client has a Health Plan and chooses to go outside their Health Plan during a Medicaid month, do not allow the expense for spenddown. Clients may have a hard time finding dental providers, if the client goes to a non-Medicaid provider during a Medicaid month for dental services, allow the expense.